FOR BHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046938

Facility Name: Barton W Stone Christian Home

Address: 873 Grove Street (Number) Jacksonville (City) 62650 (Zip Code)

County: Morgan

Telephone Number: (217) 479-3400 **Fax #** ( )

HFS ID Number: 370909086029

Date of Initial License for Current Owners: 2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/06/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig L. Ater

(Title) Senior V.P. & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	185	Skilled (SNF)	185	49,950	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	24	Sheltered Care (SC)	24	6,480	5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	56,430	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,837	21,319	3,661	42,817	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	1,276	3,102	0	4,378	12
13	DD 16 OR LESS					13
14	TOTALS	19,113	24,421	3,661	47,195	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.63%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 2005

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,661

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Barton W Stone Christian Home # 0046938 **Report Period Beginning:** 04/06/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	327,832	23,340		351,172		351,172	9,225	360,397			1
2	Food Purchase		226,444		226,444		226,444	1	226,445			2
3	Housekeeping	197,096	19,842		216,938		216,938	10	216,948			3
4	Laundry	79,256	16,779		96,035		96,035		96,035			4
5	Heat and Other Utilities			192,425	192,425		192,425	2,912	195,337			5
6	Maintenance	87,631	47,296	34,815	169,742		169,742	24,399	194,141			6
7	Other (specify):*											7
8	**TOTAL General Services**	691,815	333,701	227,240	1,252,756		1,252,756	36,547	1,289,303			8
	B. Health Care and Programs											
9	Medical Director			250	250		250		250			9
10	Nursing and Medical Records	2,045,943	109,998	2,352	2,158,293		2,158,293		2,158,293			10
10a	Therapy		89,414	397,530	486,944	(100,905)	386,039		386,039			10a
11	Activities	69,655	3,956		73,611		73,611		73,611			11
12	Social Services	44,893	33	4,028	48,954		48,954		48,954			12
13	CNA Training							3,279	3,279			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,160,491	203,401	404,160	2,768,052	(100,905)	2,667,147	3,279	2,670,426			16
	C. General Administration											
17	Administrative	42,750			42,750		42,750	141,436	184,186			17
18	Directors Fees							10,500	10,500			18
19	Professional Services			370,243	370,243		370,243	(341,070)	29,173			19
20	Dues, Fees, Subscriptions & Promotions			117,045	117,045	(74,925)	42,120	(2,671)	39,449			20
21	Clerical & General Office Expenses	171,946	23,822	23,671	219,439		219,439	291,938	511,377			21
22	Employee Benefits & Payroll Taxes			567,019	567,019		567,019	75,985	643,004			22
23	Inservice Training & Education			913	913		913	1,086	1,999			23
24	Travel and Seminar			7,553	7,553		7,553	(5,554)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			114,532	114,532		114,532	3,726	118,258			26
27	Other (specify):*			10,223	10,223		10,223	(10,200)	23			27
28	**TOTAL General Administration**	214,696	23,822	1,211,199	1,449,717	(74,925)	1,374,792	165,176	1,539,968			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,067,002	560,924	1,842,599	5,470,525	(175,830)	5,294,695	205,002	5,499,697			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Barton W Stone Christian Home #0046938 **Report Period Beginning:** 04/06/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			184,221	184,221		184,221	(3,053)	181,168			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			248,838	248,838		248,838	42,934	291,772			32
33	Real Estate Taxes			89,926	89,926		89,926		89,926			33
34	Rent-Facility & Grounds							12,787	12,787			34
35	Rent-Equipment & Vehicles			12,034	12,034		12,034	851	12,885			35
36	Other (specify):*											36
37	**TOTAL Ownership**			535,019	535,019		535,019	53,519	588,538			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					100,905	100,905		100,905			39
40	Barber and Beauty Shops		21,732		21,732		21,732		21,732			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					74,925	74,925		74,925			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		21,732		21,732	175,830	197,562		197,562			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,067,002	582,656	2,377,618	6,027,276		6,027,276	258,521	6,285,797			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,357)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,812)	30		9
10	Interest and Other Investment Income	(170)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,047)	20		17
18	Fines and Penalties				18
19	Entertainment	(25,014)	24		19
20	Contributions	(200)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(823)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,502)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,374)	23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,299)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	337,820		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 337,820		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 258,521		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Barton W Stone Christian Home

ID# 0046938

Report Period Beginning: 04/06/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(2,357)	35	5
6		0	34	6
7				7
8				8
9		(27,812)	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(1,047)	20	17
18				18
19			24	19
20		(200)	27	20
21				21
22		(823)	19	22
23				23
24		(10,000)	27	24
25		(10,502)	20	25
26				26
27				27
28				28
29		(1,374)	23	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(54,115)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Barton W Stone Christian Home # 0046938 **Report Period Beginning:** 04/06/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	9,225	0	0	0	0	0	0	0	0	9,225	1
2	Food Purchase	0	0	1	0	0	0	0	0	0	0	0	1	2
3	Housekeeping	0	0	10	0	0	0	0	0	0	0	0	10	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,912	0	0	0	0	0	0	0	0	2,912	5
6	Maintenance	0	0	24,399	0	0	0	0	0	0	0	0	24,399	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	36,547	0	0	0	0	0	0	0	0	36,547	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	3,279	0	0	0	0	0	0	0	0	3,279	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	3,279	0	0	0	0	0	0	0	0	3,279	16
	C. General Administration													
17	Administrative	0	0	141,436	0	0	0	0	0	0	0	0	141,436	17
18	Directors Fees	0	0	10,500	0	0	0	0	0	0	0	0	10,500	18
19	Professional Services	(823)	(369,420)	29,173	0	0	0	0	0	0	0	0	(341,070)	19
20	Fees, Subscriptions & Promotions	(11,549)	0	8,878	0	0	0	0	0	0	0	0	(2,671)	20
21	Clerical & General Office Expenses	0	0	291,938	0	0	0	0	0	0	0	0	291,938	21
22	Employee Benefits & Payroll Taxes	0	0	75,985	0	0	0	0	0	0	0	0	75,985	22
23	Inservice Training & Education	(1,374)	0	2,460	0	0	0	0	0	0	0	0	1,086	23
24	Travel and Seminar	(25,014)	0	19,460	0	0	0	0	0	0	0	0	(5,554)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,726	0	0	0	0	0	0	0	0	3,726	26
27	Other (specify):*	(10,200)	0	0	0	0	0	0	0	0	0	0	(10,200)	27
28	**TOTAL General Administration**	(48,960)	(369,420)	583,556	0	0	0	0	0	0	0	0	165,176	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,960)	(369,420)	623,382	0	0	0	0	0	0	0	0	205,002	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Barton W Stone Christian Home** **#** **0046938** **Report Period Beginning:** **04/06/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(27,812)	0	0	24,759	0	0	0	0	0	0	0	(3,053)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(170)	0	0	43,104	0	0	0	0	0	0	0	42,934	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	12,787	0	0	0	0	0	0	0	12,787	34
35	Rent-Equipment & Vehicles	(2,357)	0	0	3,208	0	0	0	0	0	0	0	851	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(30,339)	0	0	83,858	0	0	0	0	0	0	0	53,519	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(79,299)	(369,420)	623,382	83,858	0	0	0	0	0	0	0	258,521	45

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	369,420	Heritage Enterprises, Inc.	100.00%		(369,420)	4
5	V								5
6	V	10a	Adjustment for Related Organization		GreenTree Pharmacy				6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 369,420			$	$ * (369,420)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 9,225	$ 9,225	15
16	V	2	Food Purchase				1	1	16
17	V	3	Housekeeping				10	10	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				2,912	2,912	19
20	V	6	Maintenance				24,399	24,399	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				3,279	3,279	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				141,436	141,436	29
30	V	18	Directors Fees				10,500	10,500	30
31	V	19	Professional Services				29,173	29,173	31
32	V	20	Fees, Subscription, Promotions				8,878	8,878	32
33	V	21	Clerical & General Office Expenses				291,938	291,938	33
34	V	22	Employee Benefits & Payroll Taxes				75,985	75,985	34
35	V	23	Inservice Training & Education				2,460	2,460	35
36	V	24	Travel and Seminar				19,460	19,460	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				3,726	3,726	38
39	Total			$			$ 623,382	$ * 623,382	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$	$ 0	15
16	V	30	Depreciation					24,759	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					43,104	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					12,787	20
21	V	35	Rent-Equipment & Vehicles					3,208	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 83,858	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	$ 31,913	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	35,791	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	21,311	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	27,773	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	13,703	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	15,359	Ln 17 & 18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	6,086	Ln 17 & 18	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 151,936		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington,Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	$ 115,289	$ 115,276	209	$ 9,225	1
2	2	Food Purchase	Beds	2,612	25	7	0	209	1	2
3	3	Housekeeping	Beds	2,612	25	124	0	209	10	3
4	4	Laundry	Beds	2,612	25	0	0	209	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	209	2,912	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	209	24,399	6
7	7	Other	Beds	2,612	25	0	0	209	0	7
8	9	Medical Director	Beds	2,612	25	0	0	209	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	209	0	9
10	11	Activities	Beds	2,612	25	0	0	209	0	10
11	12	Social Service	Beds	2,612	25	0	0	209	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	209	3,279	12
13	14	Program Transportation	Beds	2,612	25	0	0	209	0	13
14	15	Other	Beds	2,612	25	0	0	209	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	209	141,436	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	209	10,500	16
17	19	Professional Services	Beds	2,612	25	364,592	0	209	29,173	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	209	8,878	18
19	21	Clerical & General Office Expens	Beds	2,612	25	3,648,522	3,309,912	209	291,938	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	209	75,985	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	209	2,460	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	209	19,460	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	209	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	209	3,726	24
25	TOTALS					$ 7,790,758	$ 5,312,885		$ 623,382	25

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	$	$	209	$	1
2	30	Depreciation	Beds	2,612	25	309,426		209	24,759	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			209		3
4	32	Interest	Beds	2,612	25	538,695		209	43,104	4
5	33	Real Estate Taxes	Beds	2,612	25			209		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		209	12,787	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		209	3,208	7
8	36	Other	Beds	2,612	25			209		8
9	38	Medically Nec Transportation	Beds	2,612	25			209		9
10	39	Ancillary Service Centers	Beds	2,612	25			209		10
11	40	Barber and Beauty Shops	Beds	2,612	25			209		11
12	41	Coffee and Gift Shops	Beds	2,612	25			209		12
13	42	Other	Beds	2,612	25			209		13
14								209		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,048,023	$		$ 83,858	25

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LsSalle National Bank		xx	Mortgage		04/06/06	$ 4,300,000	$ 4,185,333	04/06/11	variable	$ 234,378	1
2	LsSalle National Bank		xx	Mortgage							14,460	2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital								6
7	Central Office Allocation		xx	Working Capital								7
8												8
9	TOTAL Facility Related						$ 4,300,000	$ 4,185,333			$ 248,838	9
	B. Non-Facility Related*											
10	Interest Income										(170)	10
11												11
12	Central Office Allocation										43,104	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 42,934	14
15	TOTALS (line 9+line14)						$ 4,300,000	$ 4,185,333			$ 291,772	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Barton W Stone Christian Home # 0046938 **Report Period Beginning:** 04/06/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	89,926	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	89,926	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Barton W Stone Christian Home COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0046938

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	None paid in 2005	Barton W Stone Christian Home	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,796 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	209				$ 3,295,725	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Facility Sign			2005	1,050						9
10	Cabinets			2005	5,864						10
11	Ansul System			2005	1,600						11
12	Heat Detectors			2005	1,777						12
13	Door System			2005	17,554						13
14	A/C Unit			2005	10,456						14
15	Door			2005	1,593						15
16	Wiring			2005	1,280						16
17	A/C Compressor			2005	2,849						17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							24,759	24,759		34
35	Book Depreciation					63,894		63,894		63,894	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,339,748	$ 63,894		$ 88,653	$ 24,759	$ 63,894	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,339,748	$ 63,894		$ 88,653	$ 24,759	$ 63,894	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,339,748	$ 63,894		$ 88,653	$ 24,759	$ 63,894	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 800,000	$ 92,515	$ 92,515	$		$ 92,515	71
72	Current Year Purchases	72,461						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 872,461	$ 92,515	$ 92,515	$		$ 92,515	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,312,209	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 156,409	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 181,168	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 24,759	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 156,409	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments	$ 1,492,161	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 1,492,161	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 12,885 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - ☐ YES
   - ☐ NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 133,854	$		$ 133,854	1
2	Licensed Speech and Language Development Therapist		hrs			64,022			64,022	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			187,828	335		188,163	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				89,079		89,079	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					11,826			11,826	13
14	TOTAL			$		$ 397,530	$ 89,414		$ 486,944	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Barton W Stone Christian Home # 0046938 **Report Period Beginning:** 04/06/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 300	$	1
2	Cash-Patient Deposits	15,509		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	920,195		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	167		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,164,970)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (228,799)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	129,000		13
14	Buildings, at Historical Cost	4,810,101		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	872,461		16
17	Accumulated Depreciation (book methods)	(184,221)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	81,937		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,709,278	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,480,479	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 415,779	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,509		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	304,407		30
31	Accrued Taxes Payable (excluding real estate taxes)	53,819		31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,773		32
33	Accrued Interest Payable	27,754		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deposit	525		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 908,566	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,492,833		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,492,833	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,401,399	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 79,080	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,480,479	$	48

***(See instructions.)**

Facility Name & ID Number Barton W Stone Christian Home **#** 0046938 **Report Period Beginning:** 04/06/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		79,080	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	79,080	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	**TOTAL Transfers (sum of lines 18-22)**	$		23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	79,080	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,764,437	1
2	Discounts and Allowances for all Levels	(815,694)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,948,743	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	943,032	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 943,032	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	9,299	12
13	Barber and Beauty Care	27,403	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	178,259	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	14,157	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 229,118	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	170	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 170	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,121,063	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,252,756	31
32	Health Care	2,768,052	32
33	General Administration	1,449,717	33
	B. Capital Expense		
34	Ownership	535,019	34
	C. Ancillary Expense		
35	Special Cost Centers	21,732	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Non-Care	14,707	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,041,983	40
41	**Income before Income Taxes (line 30 minus line 40)****	79,080	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 79,080	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,504	1,624	$ 39,336	$ 24.22	1
2	Assistant Director of Nursing	1,261	1,301	25,810	19.84	2
3	Registered Nurses	5,125	5,698	118,004	20.71	3
4	Licensed Practical Nurses	37,444	38,734	679,979	17.56	4
5	CNAs & Orderlies	102,744	106,884	1,141,196	10.68	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,205	3,363	41,618	12.38	8
9	Activity Director					9
10	Activity Assistants	7,311	7,560	69,655	9.21	10
11	Social Service Workers	2,617	2,787	44,893	16.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,249	33,909	327,832	9.67	15
16	Dishwashers					16
17	Maintenance Workers	7,075	7,600	87,631	11.53	17
18	Housekeepers	18,997	20,765	197,096	9.49	18
19	Laundry	9,069	9,466	79,256	8.37	19
20	Administrator	1,425	1,500	42,750	28.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,157	10,739	171,946	16.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	240,183	251,930	$ 3,067,002 *	$ 12.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		250		36
37	Medical Records Consultant		900		37
38	Nurse Consultant				38
39	Pharmacist Consultant		0		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,028		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 5,178		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mignon Goodpasture			$ 42,750
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 42,750

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage enterprises	Mgt Fees	$ 369,420
		0
		0
		0
		823
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 370,243

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,441
Unemployment Compensation Insurance	55,045
FICA Taxes	234,626
Employee Health Insurance	222,305
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	6,602
Employee Benefits - central office	75,985
TOTAL (agree to Schedule V, line 22, col.8)	$ 643,004

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	18,908
Health Care Worker Background Check	
(Indicate # of checks performed)	3,180
Central Office Allocation	8,878
Promotional Advertising	1,422
Public Relations	9,080
Dues and Subscriptions	8,151
License and Fees	1,379
Less: Public Relations Expense	(9,080)
Non-allowable advertising	(1,047)
Yellow page advertising	(1,422)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,449

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,526
	64
Seminar Expense	2,963
	(25,014)
	19,460
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Barton W Stone Christian Home # 0046938 Report Period Beginning: 04/06/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **74,925**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **4,001**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

BASIC CHARGE-PRIVATE & VA	-5,707,797	
PRIVATE ASSESSMENT TAX INCOME		
BASIC CHARGE-IPA	0	
BASIC CHARGE-MEDICARE	0	
DAY CARE/HOME CARE		
LIGHT NURSING CARE	0	
MEDIUM NURSING CARE		
HEAVY NURSING CARE		
NURSING SUPPLIES-PRIVATE	-48,387	
NURSING SUPPLIES-IPA		
NURSING SUPPLIES MED PT A		
NURSING SUPPLIES MED PT B		
DRUGS	-178,259	
DRUGS-OTHER		
PT-PRIVATE	-643,032	
PT-IPA		
PT-MEDICARE PART A		
PT-MEDICARE PART B		
PT-MEDICARE ASSESSMENT INC		
LABORATORY INCOME		
SPEECH/OT-PRIVATE		
SPEECH/OT-IPA		
SPEECH/OT-MED PART A		
SPEECH/OT MED PART B		
IPA DISCOUNTS	811,694	
MEDICAID PART B DISCOUNT		
MEDICARE DISCOUNTS		
ASSESSMENT TAX EXPENSE		
RENT INCOME	0	
BEAUTY SHOP	-27,483	
ACTIVITY FUND INCOME	-6,425	
ACTIVITY FUND EXPENSE	-2,074	
MANAGEMENT FEES		
EQUIPMENT RENTAL	-8,253	
RESIDENT TRANSPORTATION	-12,844	
MISC INCOME	-1,313	
GENERAL & ADMINIST WAGES	157,826	171,946
ADMINISTRATOR WAGES	42,750	42,750
VACATION & SICK - G&A	14,120	
EMPLOYEE BENEFITS	4,602	547,019
EMPLOYEE HEPETITIS VACCINE	0	
EMPLOYEE SCHOLORSHIP WAC	0	
EMPLOYEE SCHOLORSHIP COST	0	
DIRECTORS FEES		
OFFICE EXPENSES	23,822	23,822
TELEPHONE	23,671	23,671
TRAINING & EMPLOYEE DEVL	913	913
GENERAL TRAVEL	4,526	7,223
MEAL EXPENSE FOR TRAVEL	64	
EDUCATION & SEMINAR	2,963	
HELP WANTED ADVERTISING	18,908	117,045
PROMOTIONAL ADVERTISING	1,422	
PUBLIC RELATIONS	9,080	
LICENSES & FEES	75,394	
DUES & SUBSCRIPTIONS	8,151	
CONTRIBUTIONS	100	
PROFESSIONAL FEES	823	370,243
AUDIT & ACCT FEES	250	250
UTILIZATION REVIEW	0	
OTHER PHYSICIAN FEES	0	
MEDICAL RECORDS CONSULT	900	
PHARMACIST FEES	0	
SOC SERV/ACT CONSULT	4,028	4,028
TV RENTAL	4,135	
INCOME TAXES		10,223
BACKGROUND CHECKS	3,180	
PAYROLL TAXES	285,234	
PAYROLL TAXES ADMINIST	4,437	
PAYROLL TAXES	222,555	
LIABILITY INSURANCE	114,532	114,532
INSURANCE-OWNERS		
WORKMENS COMP INSURANCE	48,441	
CENTRAL OFFICE FEES	369,420	
BAD DEBTS	10,000	
LOST ITEMS-RESIDENTS	23	
MISCELLANEOUS	0	
REAL ESTATE TAXES	69,926	89,926
LEASED EQUIPMENT	7,886	12,034
MAINTENANCE SALARIES	80,969	87,631
MAINTENANCE SICK & VAC	6,662	
ELECTRIC	117,966	192,425
NATURAL GAS	55,800	
HEATING & DIESEL OIL		
WATER & SEWER	18,560	
TRASH COLLECTION	14,760	34,815
PROPERTY PLANT REPLACEMN	10,364	47,296
GENERAL REPAIR & MAINT	36,932	
MAINTENANCE CONTRACTS	20,055	
DIETARY WAGES	301,197	327,832
DIETARY SICK & VAC	25,635	
SALES TAX		
FOOD PURCHASES	230,445	236,444
SUPPLIES-DISHWASHING	7,913	23,340
DIETARY REPLACEMENT	6,004	
DIETARY SUPPLIES-PAPER	9,227	
MEAL CREDIT	-4,001	
LAUNDRY WAGES	74,432	79,256
LAUNDRY SICK & VAC	4,824	
LAUNDRY REPLACEMENT	9,586	16,779
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	7,273	
HOUSEKEEPING WAGES	179,482	197,096
HOUSEKEEPING SICK & VAC	17,614	
HOUSEKEEPING SUPPLIES	4,188	19,842
HOUSEKEEPING SUPPLIES-PPR	15,673	
RN WAGES-MEDICARE		2,045,943
RN WAGES-NON MEDICARE	165,691	
RN BONUSES	25,000	
ADON	25,810	
RN SICK & VACATION	12,313	
LPN WAGES-MEDICARE	0	
LPN WAGES-NON MEDICARE	632,066	
LPN WAGES OTHER		
LPN SICK & VACATION	47,913	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	1,055, 178	
WARD CLERKS		
AIDE VACATION & SICK	86,018	
CONTRACT NURSES-RN	0	
CONTRACT NURSES-LPN	0	
CONTRACT NURSES-AIDES	0	
NURSE AIDE TRAINING WAGES	0	0
NURSE AID TRAINING EXP	0	0
NURSE AIDE TRAINING REIMB	0	
REHAB WAGES	38,966	
REHAB SICK & VAC	2,652	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	83,129	169,998
NURSING SUPPLIES	23,436	
REPLACEMENT-NURSING	3,433	
NURSING-OTHER	1,452	2,352
DRUG PURCHASES	79,503	89,414
DRUG PURCHASES-OTHER	1,911	
LABORATORY SERVICES	11,826	397,530
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITES WAGES	64,882	69,655
ACTIVITIES SICK & VAC	4,773	
ACTIVITIES SUPPLIES	3,956	3,956
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	167,028	
PT SUPPLIES	335	
SOCIAL SERVICE WAGES	41,430	44,893
SOCIAL SERVICE SICK & VAC	3,463	
SOCIAL SERVICE EXPENSES	33	33
OT FEE	133,854	
SOCIAL THERAPIST FEE	0	0
SPEECH THERAPY FEE	64,022	
BEAUTICIAN WAGES		0
BEAUTICIAN SICK & VAC		
BEAUTICIAN FEES	0	0
BEAUTY SHOP SUPPLIES	21,732	21,732
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC		
VOL COORD SUPPLIES	0	
RENT		0
INTEREST EXPENSE	214,378	248,838
DEPRECIATION	184,221	184,221
LOAN FEE AMORTIZATION	14,460	
INTEREST INCOME	-170	
MISC NON-OPERATING INCOME	0	
INCOME TAXES	14,707	
	6,041,813	6,027,276
		-14,537
	-76,080	
	(NET INCOME)	
	0	

						2,612	209	3,471,750	71,391,262		
	Name	Title	Function	Total Pay	usted by Mgmt F	otal # Beds	acility # Be	on-Nursing Hor	Nursing Home	This Facility	
###	Susie Jefferson	Director	Manageme	418,245	418,245			19,396	398,849	31,913	
###	Tom Jefferson	Secretary	Manageme	0	0			0	0	0	
###	Craig Hart	Chairman	Manageme	469,049	469,049			21,752	447,297	35,791	
###	Cheryl Lowney	Executive Vice Presic	Manageme	279,290	279,290			12,952	266,338	21,311	
###	Steve Wannemache	President	Manageme	363,969	363,969			16,879	347,090	27,773	
###	Connie Hoselton	Sr Vice President	Manageme	179,584	179,584			8,328	171,256	13,703	
###	Craig Ater	Sr Vice President	Manageme	201,279	201,279			9,334	191,945	15,359	
	Ben Hart			79,758	79,758			3,699	76,059	6,086	
13				1,991,174	1,991,174				1,898,834	151,936	